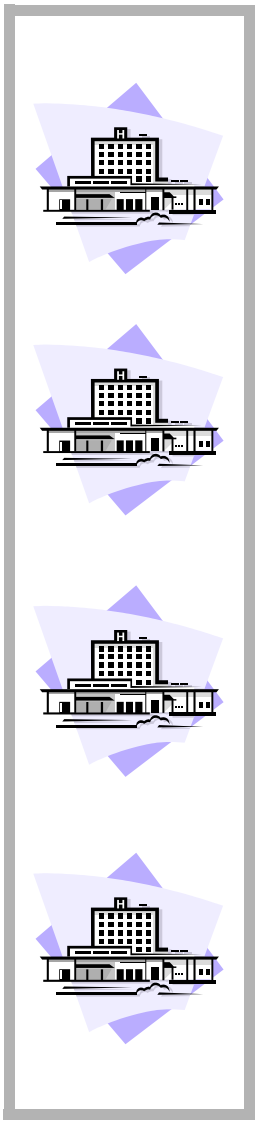

Critical Access and Exempt Hospital Services

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

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My Medicaid Provider ID Number:

Bundled Services

Outpatient hospital services preceding an inpatient hospital admission must not be bundled into the inpatient claim.

Multiple Services on Same Date

Hospital providers must submit a single claim for all services provided to the same client on the same day. If services are repeated on the same day, use appropriate modifiers.

Reporting Service Dates

- All line items must have a valid date of service in form locator (FL) 45.
- The following revenue codes require a separate line for each date of service and a valid CPT or HCPCS Level II code:

Revenue Codes That Require a Separate Line for Each Date of Service and a Valid CPT or HCPCS Code for Outpatient Services Only

26X	IV Therapy	51X	Clinic
28X	Oncology	52X	Free-Standing Clinic
30X	Laboratory	61X	Magnetic Resonance Imaging (MRI)
31X	Laboratory Pathological	63X	Drugs Requiring Specific Identification
32X	Radiology – Diagnostic	70X	Cast Room
33X	Radiology – Therapeutic	72X	Labor Room/Delivery
34X	Nuclear Medicine	73X	Electrocardiogram (EKG/ECG)
35X	Computed Tomographic (CT) Scan	74X	Electroencephalogram (EEG)
36X	Operating Room Services	75X	Gastro-Intestinal Services
38X	Blood	76X	Treatment or Observation Room
39X	Blood Storage and Processing	77X	Preventive Care Services
40X	Other Imaging Services	79X	Lithotripsy
41X	Respiratory Services	82X	Hemodialysis-Outpatient or Home
42X	Physical Therapy	83X	Peritoneal Dialysis-Outpatient or Home
43X	Occupational Therapy	84X	Continuous Ambulatory Peritoneal Dialysis (CAPD0-Out-patient
44X	Speech-Language Pathology	85X	Continuous Cycling Peritoneal Dialysis (CCPD)-Outpatient
45X	Emergency Department	88X	Miscellaneous Dialysis
46X	Pulmonary Function	90X	Psychiatric/Psychological Treatments
47X	Audiology	91X	Psychiatric/Psychological Services
48X	Cardiology	92X	Other Diagnostic Services
49X	Ambulatory Surgical Care	94X	Other Therapeutic Services

Using Modifiers

- Review the guidelines for using modifiers in the most current CPT-4 book, HCPCS Level II book, and other helpful resources (e.g., CPT Assistant, APC Answer Letter and others).
- Always read the complete description for each modifier; some modifiers are described in the CPT-4 manual while others are in the HCPCS Level II book.
- The Medicaid claims processing system recognizes only one modifier. The modifier must be added to the CPT/HCPCS code without a space or hyphen in form locator (FL) 44. For example, 25680 (treatment of wrist fracture) when done bilaterally is reported as 2568050.
- Since the Medicaid claims processing system can read only one modifier per line, it is important to report the most important modifier first. In this case, the most important modifiers for Medicaid are those that affect pricing. Discontinued or reduced service modifiers must be listed before other pricing modifiers. For a list of modifiers that change pricing, see the *How Payment Is Calculated* chapter in this manual.

Number of Lines on Claim

Providers are requested to put no more than 40 lines on a UB-92 paper claim. Although additional lines may be billed on the same claim, the Department claims processing system is most efficient for claims with 40 lines or fewer. Providers can choose to combine lines or bill electronically. The electronic billing system is designed to handle more than 40 lines.

Span Bills

Outpatient hospital providers may include services for more than one day on a single claim, but the date must be shown on the line.

Split/Interim Billing

Hospitals can split bill under the following circumstances. When split billing, only include charges for the dates of service covered by the client's eligibility period.

- ***At the provider's fiscal year end***
- ***When the client has partial eligibility.*** In cases where the client has partial Medicaid eligibility for a hospital stay and Medicare has paid, the claim must be split and only Medicaid eligible charges billed. Prorate the coinsurance over the entire stay, and indicate the portion related to the Medicaid eligible period. For example, a client had a 15-day hospital stay in which she was eligible for Medicaid during 10 of those days. The client has a $300 Medicare coinsurance, which is divided by the 15 days for a total of $20 per day. Multiply $20 x the 10 Medicaid eligible days for a